DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 7/23/11

PRINTED: 06/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445024	A. BUILDING _____ B. WING _____	06/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, JOHNSON CITY	3209 BRISTOL HWY JOHNSON CITY, TN 37601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure adequate supervision for two (#12, #21) and failed to ensure safety devices were in place for three residents (#3, #5, #9) of thirty residents reviewed. The facility's failure resulted in actual harm to resident #12. The findings included: Resident #12 was admitted to the facility on November 18, 2008, with diagnoses including Atrial Fibrillation, Diabetes Mellitus, Cardiac Pacemaker, Anemia, and History of Falls. Medical record review of the Minimum Data Set dated March 2, 2011, revealed, "...moving on and off toilet...not steady, only able to stabilize with human assistance" Medical record review of the resident Care Plan dated March 3, 2011, revealed "...Problem...Impaired mobility and self care	F 323	F-323 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The DON and/or designee will in-service all caregivers related to the care of the affected residents regarding: not leaving potentially at-risk residents unattended in the bathroom; the proper use of positioning devices; the proper use of transfer techniques; and the proper use of safety alarms.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ronald Dean Messamore	Administrator	6-22-11

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 deficit with left sided hemiplegia making pt (patient)...increased risk for falls...Approaches...Observe for unsafe actions..." Medical record review of facility investigation documentation provided by the facility dated April 23, 2011, at 4:00 p.m., revealed, "...This nurse was alerted by staff that resident was in the floor in the bathroom...sent to ER (emergency department)..." Medical record review of a hospital Consultation Report dated April 23, 2011, revealed, "...yesterday...was up to commode nursing apparently stepped away...was complaining of pain in...shoulder and arm...Impression:...left clavicle fracture..." Interview and statement review completed at the time of the fall with Certified Nursing Assistant (CNA) # 1 on June 8, 2011, at 9:20 a.m., by phone confirmed that CNA #1 turned their back for a few seconds after putting the resident on the toilet. Interview with the Director of Nursing in the facility conference room on June 8, 2011, at 10:30 a.m., confirmed the resident was not to be left unobserved while in the bathroom and confirmed the CNA turned their back away from the resident resulting in a fall/fracture. Resident #9 was admitted to the facility on May 15, 2008, with diagnoses including Alzheimer's Dementia, Osteoarthritis, and History of Falls. Medical record review of the resident's Care Plan dated May 5, 2011, revealed, "problem...pt	F 323	How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents will be assessed by the RCC for the ability to be left alone in bathroom. Those identified as unsafe to be left alone will wear an arm band indicating their risk of being left alone. All residents will be assessed by RCC for proper mode of transfer. The care plan and CNA assignment sheet and/or communication board will continue to be updated with each care plan change. All residents who had falls within the last 60 days will be assessed by RCC for proper positioning devices and/or safety alarms. The care plan and CNA assignment sheet and/or communication board will continue to be updated with each care plan change.	

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F 323	Continued From page 2 (patient) at risk for falls...approaches...use wedge when pt (patient) in bed for positioning..." Medical record review of documentaion provided by the facility dated May 28, 2011, at 8:00 p.m., revealed, "Certified Nursing Assistant (CNA) heard resident's bed alarm sounding...wedge cushion not on bed...found in closet..." Interview with Resident Care Coordinator #1 on June 7, 2011, at 1:15 p.m., in the station two chart room, confirmed the wedge cushion was not on the bed at the time of the fall on May 28, 2011. Resident #21 was admitted to the facility on March 25, 2010, with diagnoses including Alcoholic Encephalopathy, Parkinson's Disease, and History of Falls. Medical record review of the resident's Care Plan updated January 13, 2011, revealed, "...problem...Impaired mobility related to Parkinson's with a history of falls and Encephalopathy; making patient at risk for falls...Approaches...Provide assistance with transfers..." Medical record review of a nurse's note dated January 14, 2011, at 3:15 p.m., revealed, "...Pt (patient) taken to bathroom per CNA. Was left to check on another resident...found resident sitting on buttocks on floor facing...chair...no injuries..." Continued medical record review of a nurse's note dated February 25, 2011, revealed, "...resident reported that...was on...way back from the bathroom and fell...no injuries..."	F 323	What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur? The administrator and/or designee will in-service all staff on fall-related safety precautions: not leaving a resident alone in BR who has an arm band; keeping alarms plugged in, proper use of safety devices/equipment. The DON and/or designee will in-service all nursing staff on the policy and procedure for fall risk arm bands and review the use of CNA assignment sheets and communication boards, which will list the residents' mode of transfer and positioning/safety devices. The shift charge nurse will review CNA assignment sheets and/or communication board with CNAs at the beginning of shift. The shift charge nurse will review/update the assignment sheets and/or communication board according to the patient's plan of care.	

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F 323	Continued From page 3 Medical record review of the January 14, 2011, post fall interventions revealed, "...intervention after fall...resident not to be left alone in bathroom..." Interview with the Resident Care Coordinator #2 on June 8, 2011, at 9:45 a.m., confirmed the resident was left unattended at the time of the fall on the January 14, 2011, and February 25, 2011. Resident #3 was admitted to the facility on August 23, 2007, with diagnoses including Congestive Heart Failure, Right Hemiparesis, Diabetes, and Atrial Fibrillation. Medical record review of the Minimum Data Set dated March 28, 2011, revealed the resident required extensive assistance with two persons physical assist for transfers, and extensive assistance with two persons physical assist for toilet use. Medical record review of the post falls nursing assessment dated April 14, 2011, revealed, "...CNA (certified nursing assistant) was transferring resident to bathroom when...legs gave way. The CNA lowered...to the floor...(no injuries) Inservice staff on gait belt (and) 2 assist..." Medical record review of the post falls nursing assessment dated April 19, 2011, revealed, "...CNA was transferring resident from the toilet to (named brand) chair when...has to slide (resident)...to the floor (until) help came ...(no injuries)"	F 323	How the corrective action will be monitored to ensure the deficient practice will not recur, ie: what quality assurance program will be put into place? The RCC will make rounds on all residents with arm bands at least 3 times per week for 4 weeks, then once per week thereafter. The RCC will select a sample of 5 residents once per week for 4 weeks to review the care plan and CNA assignment sheets and/or communication board to ensure they are accurate. The RCC will submit a report/log of their rounds to the QA committee (Administrator, DON, ADON, Rehab Director, Dietary Manager, Social Services Director, Housekeeping Director, Health Information Director, and Medical Director) on a monthly basis.	

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F 323	Continued From page 4 Observation on June 6, 2011, at 4:15 p.m., revealed the resident lying on the bed. Interview on June 7, 2011, at 4:10 p.m., at the nursing station, with Resident Care Coordinator #1, confirmed a gait belt or two person assistance had not been used when transferring the resident at the time of the fall on April 19, 2011. Resident #5 was admitted to the facility on March 15, 2006, with diagnoses including Osteoporosis, Hypertension, and Atrial Fibrillation. Medical record review of the high risk patient selection form dated March 1, 2011, revealed the resident had three falls in February 2011 and had poor safety awareness. Medical record review of the care plan dated May 26, 2011, revealed, "...use bed cushion alarm..." Observation on June 7, 2011, at 12:45 p.m., revealed the resident lying on the bed with the pressure pad alarm cord hanging down the side of the bed with no alarm box. Interview on June 7, 2011, at 12:45 p.m., in the resident's room, with Resident Care Coordinator #1, confirmed the alarm box was not attached to the pressure pad alarm.	F 323		